COUNTY OF LOS ANGELES
Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL SERVICE AUTHORIZATION REQUEST FORM

SUBMIT SERVICE AUTHORIZATION REQUEST FORM TO:
Website: http://publichealth.lacounty.gov/sapc/
Fax: (xxx) xxx-xxxx

1.(Check One): ☐ Preauthorization ☐ Authorization ☐ *Expedited Authorization ☐ Reauthorization (Provide Current Authorization #:_____)

2. Admission Date (if different from submission date):	3. Submission Date:	4. Submission Time:	5. Dates Service Requested: From:_____ To:_____

PATIENT INFORMATION

6. Name (Last, First, and Middle):	7. Date of Birth (MM/DD/YY):	8. Medi-Cal or My Health LA Number: Verified Eligibility: ☐Yes ☐ No
9. Address:		
10. Phone Number: Okay to Leave a Message? ☐ Yes ☐ No		11. Gender:
12. Perinatal Patient: ☐ Yes ☐ No If yes, provide verification	13. Criminal Justice Involved Patient: ☐ Yes ☐ No If yes, provide verification with Criminal Justice Identification Number: _____	14. Race/Ethnicity (Optional):

PROVIDER AGENCY INFORMATION

15. Provider Agency Name:	16. Phone Number:	17. Fax Number:
18. Address:		19. Email Address:
20. Name and Work Title of the Contact Person:		21. Phone Number of the Contact Person:

☐ ORDERING PRESCRIBER (FOR MEDICATION-ASSISTED TREATMENT)

22. Name and Credential of Prescriber:	23. Phone Number:
24. Address:	25. Email Address

26. REQUIRED CLINICAL INFORMATION – DIAGNOSTIC AND STATISTICAL MANUAL (DSM)- 5 DIAGNOSES

27. CARE REQUESTED (CHECK ONE)

Preauthorized Service	Authorized Service
☐ 3.1 Clinically Managed Low-Intensity Residential Services: 24-hour structure with available trained personnel; at least 5 hours of clinical service/week and prepare for Outpatient treatment. ☐ 3.3 Clinically Managed Population-Specific High-Intensity Residential Services (this level of care is not designated for adolescent populations): 24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community and prepare for outpatient treatment. ☐ 3.5 Clinically Managed High-Intensity Residential Services: 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community.	☐ Recovery Bridge Housing ☐ Medication-Assisted Treatment for Youth Under Age 18 **Withdrawal Management for Youth Under Age 18:** ☐ 1-WM Withdrawal Management, Ambulatory – Mild: Ambulatory withdrawal management without extended onsite monitoring for mild withdrawal with daily or less than daily outpatient supervision. ☐ 2-WM Withdrawal Management, Ambulatory – Moderate: Ambulatory withdrawal management with extended onsite monitoring for moderate withdrawal with all-day withdrawal management, support, and supervision; at night has supportive family or living situation. ☐ 3.2-WM Withdrawal Management, Clinically Managed - Moderate: Clinically managed residential withdrawal management for moderate withdrawal that needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.

28. REQUIRED DOCUMENTATION

Please refer below for required documentation for respective preauthorizations, authorizations, and reauthorizations.

INTERNAL SAPC USE ONLY

☐ Approved (Authorization #:_____) ☐ Denied

If denied, reason(s):_____

Reviewed by:_____ Date:_____

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code, HIPAA Privacy Standards, and 42 CFR Part 2. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.

Patient Name:_____ **Medi-Cal ID:**_____

Treatment Agency_____

SERVICE AUTHORIZATION FORM INSTRUCTIONS

1. Check the appropriate box for what is being requested: preauthorization, authorization, expedited authorization or reauthorization. If requesting a reauthorization, enter the current authorization number.
   **Expedited Authorization: For cases in which a provider indicates, or SAPC determines, that following the standard timeframe could seriously jeopardize the patient's life or health, or ability to attain, maintain, or regain maximum function, SAPC must make an expedited authorization decision and provide notice as expeditiously as the patient's health condition requires, and no later than 3 working days after receipt of the request for service.*
2. Enter the admission date for patient, if different from submission date.
3. Enter the submission date of when the Service Authorization Request Form was submitted.
4. Enter the submission time.
5. Enter the dates for service requested: enter the date the requested service will begin and the date the requested service will end.
   - ***Note**: the duration for the initial residential authorization for adults cannot exceed sixty (60) calendar day, and thirty (30) calendar days for adolescents; the duration for residential reauthorizations and authorizations for medication-assisted treatment for youth under age 18 cannot exceed thirty (30) calendar days.*

PATIENT INFORMATION

6. Enter the patient's name in the order of last name, first name, and middle name.
7. Enter the patient's date of birth.
8. Enter patient's Medi-Cal number and indicate if Medi-Cal eligibility has been verified or enter My Health LA number.
9. Enter patient's address.
10. Enter the patient's phone number. Check box to indicate if it is okay to leave a message at this phone number.
11. Enter the patient's gender.
12. Check box if the patient is a perinatal patient. Must provide verification of perinatal status by submitting documentation or a written statement from qualified individuals, including the physician, physician's assistant, certified nurse midwife, nurse practitioner, or other designated medical or clinic personnel with access to the patient's medical records. The statement must give the estimated date of confinement or the last date of pregnancy, and provide sufficient information to substantiate perinatal status. Authorization for the perinatal patient can be up to the length of the pregnancy and postpartum period, which is sixty (60) days after the pregnancy ends, based on medical necessity.
13. Check box if the patient is a criminal justice (CJ) patient. Must provide documentation from the applicable criminal justice agency (e.g., Superior Court, Probation, law enforcement, California Department of Corrections, etc) that indicates the patient's criminal justice involvement.
14. Enter the patient's race/ethnicity (optional).

PROVIDER AGENCY INFORMATION

15. Enter the name of the provider agency that is requesting the authorization or reauthorization.
16. Enter the phone number of the provider agency.
17. Enter the fax number of the provider agency.
18. Enter the address of the provider agency.
19. Enter the email address of the provider agency.
20. Enter the name and the work title of the person who can be contacted regarding the request.
21. Enter the phone number of the provider agency's contact person.

ORDERING PRESCRIBER (FOR MEDICATION ASSISTED TREATMENT)

22. Enter the name and credential of the prescriber.
23. Enter the prescriber's phone number.
24. Enter the prescriber's address.
25. Enter the prescriber's email address.

REQUIRED CLINICAL INFORMATION – DIAGNOSTIC AND STATISTICAL MANUAL DIAGNOSES

26. Enter the DSM-5 diagnoses. At least one diagnosis must be for a substance use disorder.

LEVEL OF CARE REQUESTED

27. Check the appropriate box for the level of care requested.

Preauthorized Service

- 3.1 Clinically Managed Low-Intensity Residential Services: 24-hour structure with available trained personnel; at least 5 hours of clinical service/week and prepare for Outpatient treatment.
- 3.3 Clinically Managed Population-Specific High-Intensity Residential Services (this level of care is not designated for adolescent populations): 24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community and prepare for outpatient treatment.
- 3.5 Clinically Managed High-Intensity Residential Services: 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community.

Authorized Service

- Recovery Bridge Housing
- Medication Assisted Treatment for patients under age 18.

Withdrawal Management for Patients Under 18:

- 1-WM, ambulatory withdrawal management without extended onsite monitoring for mild withdrawal with daily or less than daily outpatient supervision.
- 2-WM, ambulatory withdrawal management with extended onsite monitoring for moderate withdrawal with all-day withdrawal management, support, and supervision; at night has supportive family or living situation.
- 3.2-WM, clinically managed residential withdrawal management for moderate withdrawal that needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.

28. REQUIRED DOCUMENTATION

- For preauthorization for residential services:
  Submit application for preauthorized residential services prior to initiation of services, unless providers elect to provide the service prior to receiving preauthorization, and accept financial loss if the preauthorization is ultimately denied. Required documents: 1. Service Authorization Request Form. 2. Assessment information.
- For authorization of Recovery Bridge Housing:
  Documentation that serves as proof that patient is actively enrolled in Outpatient or Intensive Outpatient treatment, and documentation of patient's need of a stable, safe, living environment in order to best support their recovery
- For authorization of Medication-Assisted Treatment (MAT) for patients under age 18:

Required documents: 1. Service Authorization Request Form. 2. Assessment information. 3. Justification for the prescribed medication(s): name, dosage, route, frequency, duration, and relevant laboratory results (if available). 4. Relevant prior history.

- For authorization of Withdrawal Management for Youth Under Age 18

  Required documents: 1. Service Authorization Request Form. 2. Assessment information.

Reauthorizations* (*Reauthorizations are not applicable for Recovery Bridge Housing or youth withdrawal management)

- For reauthorization of residential services:

  Reauthorization is required every thirty (30) calendar days after the initial sixty (60) day authorization. Reauthorization request must be submitted at least seven (7) calendar days in advance of end date of current authorization. Required documents: 1. Service Authorization Request Form. 2. Current treatment plan. 3. Assessment information. 4. Progress notes. 5. Relevant laboratory test results (if available). 6. Verification of perinatal status and/or criminal justice status (if applicable).

- For reauthorization of MAT for patients under age 18:

  For MAT for youth, reauthorization is required every thirty (30) calendar days. Request must be submitted at least seven (7) calendar days in advance of end date of prior youth MAT authorization. Required documents: 1. Service Authorization Request Form. 2. Current treatment plan. 3. Justification for the prescribed medication(s): name, dosage, route, frequency, duration, and rationale. 4. Assessment information**.** 5. Progress notes. 6. Relevant laboratory test results (if available). 7. Verification of perinatal status and/or criminal justice status (if applicable).

INTERNAL SAPC USE ONLY

This section reserved for internal SAPC use only.

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